Local No. 1591-88 **990504**

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

~~Rees Funeral Home~~ / 600 W Ridge Rd / Hobart

State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME First: ANDREW Middle: Last: STYGAR
2. SEX: M
3. DATE OF DEATH (Mo. Day, Yr.): JULY 29, 1988
4. SOCIAL SECURITY NUMBER: 307-01-7802
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR Months / Days:
5c. UNDER 1 DAY Hours / Minutes:
6. DATE OF BIRTH (Month, Day, Year): 3-28-1910
7. BIRTHPLACE (City and State or Foreign Country): SO. CHICAGO, ILL.
8. YEAR LAST SERVED IN U.S. ARMED FORCES?
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): JOSEPHINE STAPINSKI
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CRANE OPERATOR
12b. KIND OF BUSINESS/INDUSTRY: U.S. STEEL CORP.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: HOBART
13d. STREET AND NUMBER: 265 N. WISCONSIN ST.
13e. INSIDE CITY LIMITS? (Yes or no): YES
13f. FARM: NO
13g. ZIP CODE: 46342
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) [X] No [ ] Yes Specify:
15. RACE—American Indian, Black, White, etc. (Specify): WHITE
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): ANTHONY STYGAR (DEC)
18. MOTHER'S NAME (First, Middle, Maiden Surname): SOPHIE PIENTA (DEC)

INFORMANT

19a. INFORMANT'S NAME (Type/Print): JOSEPHINE STYGAR
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 265 N. WISCONSIN ST. HOBART, IN 46342
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): 8-1-88 CALVARY CEMETERY
20c. LOCATION—City or Town, State: PORTAGE, IN
21a. SIGNATURE OF FUNERAL DIRECTOR: Gerald Rees
21b. LICENSE NUMBER (of Licensee): FDE1041083
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOME FDH3003069 600 W OLD RIDGE RD, HOBART, IN 46342

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death
23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 2:45P M
25. DATE PRONOUNCED DEAD (Month, Day, Year): JULY 29, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): NO

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardio-pulmonary Arrest —
DUE TO (OR AS A CONSEQUENCE OF): b. Cardiac Failure — days
DUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic Heart Disease — yrs.
DUE TO (OR AS A CONSEQUENCE OF): d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

FILED AUG 4 1988 — Carol M. Pastor, Lake County

CERTIFIER (SEE INSTRUCTIONS)

29a. [ ] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
[ ] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER [ ] CORONER [ ] HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. J. Krsek M.D.
29c. LICENSE NUMBER: 16778
29d. DATE SIGNED: July 29 1988
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): KRSEK, M.D. 10 N. MICHIGAN AVE. HOBART, IN 46342

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. AUG 3 1988 — LAKE COUNTY HEALTH COMMISSIONER

HEALTH OFFICER

31. SIGNATURE OF REGISTRAR
32. DATE FILED (Month, Day, Year): August 1, 1988

LILLIAN A. BUSTICK RECORDER, LAKE COUNTY CROWN POINT, INDIANA 46307 — FILED AUG 10 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

SBH06-004 State Form 10110 Rev 10/87 DEATH PD 1

Fairfield add Lt 23 #17-156-16 358 40